Universal Health Care
Model Summaries – Expenditures and Revenues

October 29, 2020

Introduction

This document provides a summary of results for each of the three models being evaluated. Results for the universal coverage options (Models A and B) are stratified based on status quo payer sources and status quo revenue sources.

Presentation Changes

Based on questions and feedback to-date, projections have been updated and include changes to how results are presented to make it easier to interpret results and to isolate major decision points. The updated projections include refinement of assumptions used to project expenditures, particularly for current payer sources that required use of national survey data instead of actual reported expenditures. Key differences from the prior projections include the following:

- Except for the Medicaid eligible population, dental services and long-term care have been removed from the model for purposes of illustrating the revenue sources in the tables below. The incremental costs of providing dental services for the entire populations are illustrated separately.
- Coverage for individuals with Medicare has been added to the projections.
- Cascade Care is now included in the "Private Health Insurance" category. This change is because an estimate for projected enrollment in the standard and public option plans is not available. It is likely that a projection will not be available until after the initial enrollment period.
- Revenue assumptions have been incorporated.
- Model A now illustrates projected results for both the first year of implementation and an estimate for steady state that does not reflect transition time.
- Trend factors and estimates for Model A for calendar year 2022 and beyond are provided.

Outstanding Model Refinements

There are several outstanding assumptions that may be updated in the final iteration if additional information can be obtained to improve the accuracy of the current assumptions. These assumptions include:

- Relative level of reimbursement between Medicaid and Medicare for specific services categories. This assumption can significantly impact the revenue projection.
- Washington public program expenditures, population, and funding source estimates. (e.g. federal Medicaid revenue, legislative appropriations, etc.)
- Cascade Care and subsidy program final estimates.

Content Guide

The remainder of this document is organized into the following sections:

Model A Universal Coverage – State Administered
Steady State

Overview Model A

Covered Populations	Benefits	Cost Sharing	Provider Reimbursement	Population Specific Impacts	Administration
• Medicaid • Medicare (1) • CHIP • Private Health Insurance (employer, state employees, and exchange) • Undocumented Immigrants • Uninsured	• Essential health benefits • Dental for Medicaid Eligible Only (1) • Vision • Long-erm Care for Medicaid Eligible Only (1)	• No cost sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Administrative efficiency • Purchasing power	• Improved access for the Medicaid Eligible population • Reflects increased utilization for uninsured and Undocumented Immigrant populations	• State administered • Premiums are exempt from state premium tax impacting cost and revenues • Reflects reductions in system-wide administrative costs.

(1) As noted under presentation changes on page 1.

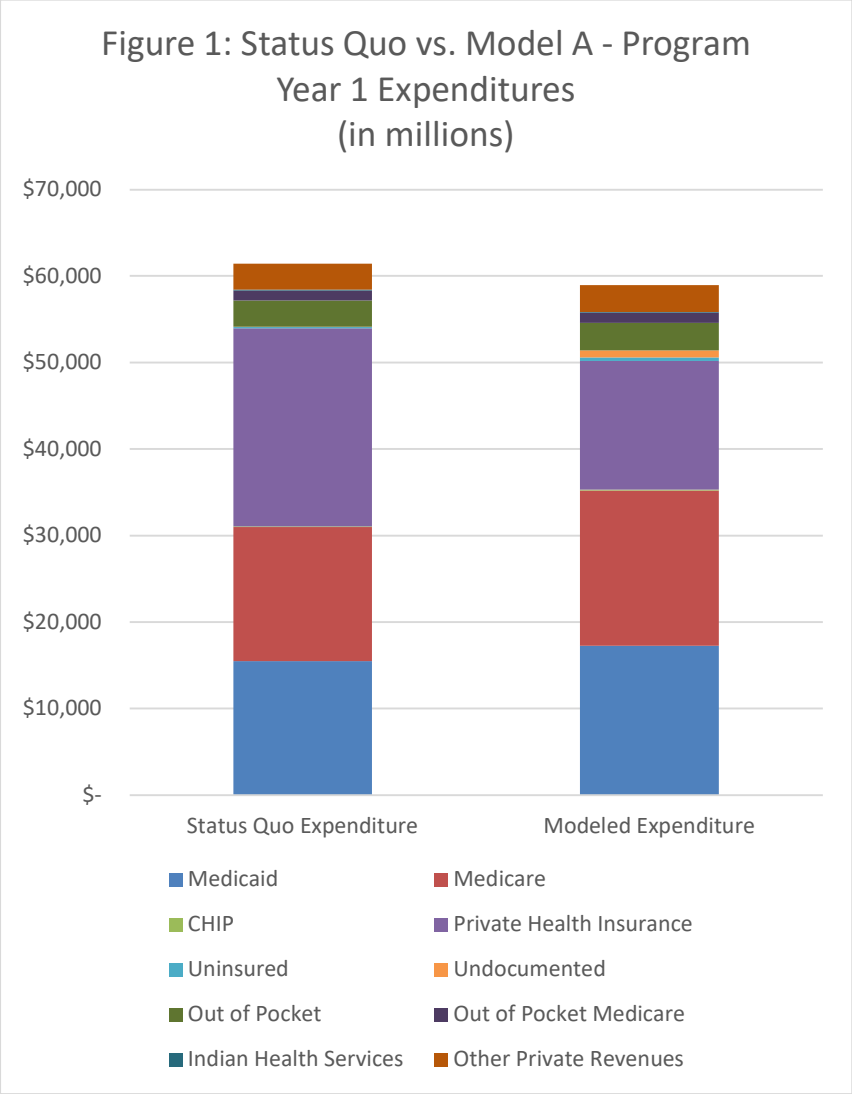
Table 1: Calendar Year 2022 Expenditure Projections – Implementation Year

Financing Source	Population (2)	Status Quo Expenditures (3)	Modeled Expenditures(3)	Differences
Medicaid	1,703,992	$15,492,152,242	$17,252,947,016	$1,760,794,774
Medicare	1,721,504	$15,478,141,127	$17,950,096,666	$2,471,955,539
CHIP	61,707	$83,298,324	$98,892,477	$15,594,153
Private Health Insurance	3,673,661	$22,899,808,044	$14,888,845,722	$(8,010,962,322)
Uninsured	333,840	$133,818,270	$411,406,833	$277,588,563
Undocumented	124,428	$44,888,791	$793,527,255	$748,638,464
Excluded Populations	277,774			
Out of Pocket Expense (excludes Medicare)		$3,045,638,137	$3,174,735,124	$129,096,987
Out of Pocket Expense (Medicare)		$1,156,180,215	$1,205,187,804	$49,007,589
Indian Health Services		$79,843,114	$77,511,016	$(2,332,098)
Other Private Revenues		$3,003,934,742	$3,088,982,108	$85,047,366
Total	**7,896,906**	**$61,417,703,006**	**$58,942,132,021**	**$(2,475,570,985)**

(2) The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare covered expenditures are included in the Medicare row.

(3) *Expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.*

Model A Universal Coverage – State Administered Steady State



Key Notes:
Model A is expected to reduce aggregate system-wide expenditures by approximately **$2.5 billion** in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system. The efficiencies reflect a phase in during the initial year. These include factors such as the following:

- Reduced payer administrative cost
- Increased purchasing power
- Health care provider administrative efficiencies
- Program integrity improvements

The following table represents projected calendar year 2022 revenue estimates by financing source. These revenue projections include consideration for cost shifting dynamics that will occur due to Universal Coverage. The reader should note the following when interpreting the figures in Table 2.

- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A Universal Coverage; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the "State / Local" row for the "Model A Revenue Estimate" column.
- Model A design includes normalizing provider reimbursement into a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payor (Medicaid, Medicare and private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State / Local" row for the "Model A Revenue Estimate" column.
- The revenue model assumes that the state will be successful in preserving federal funding streams for eligible populations even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 1 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

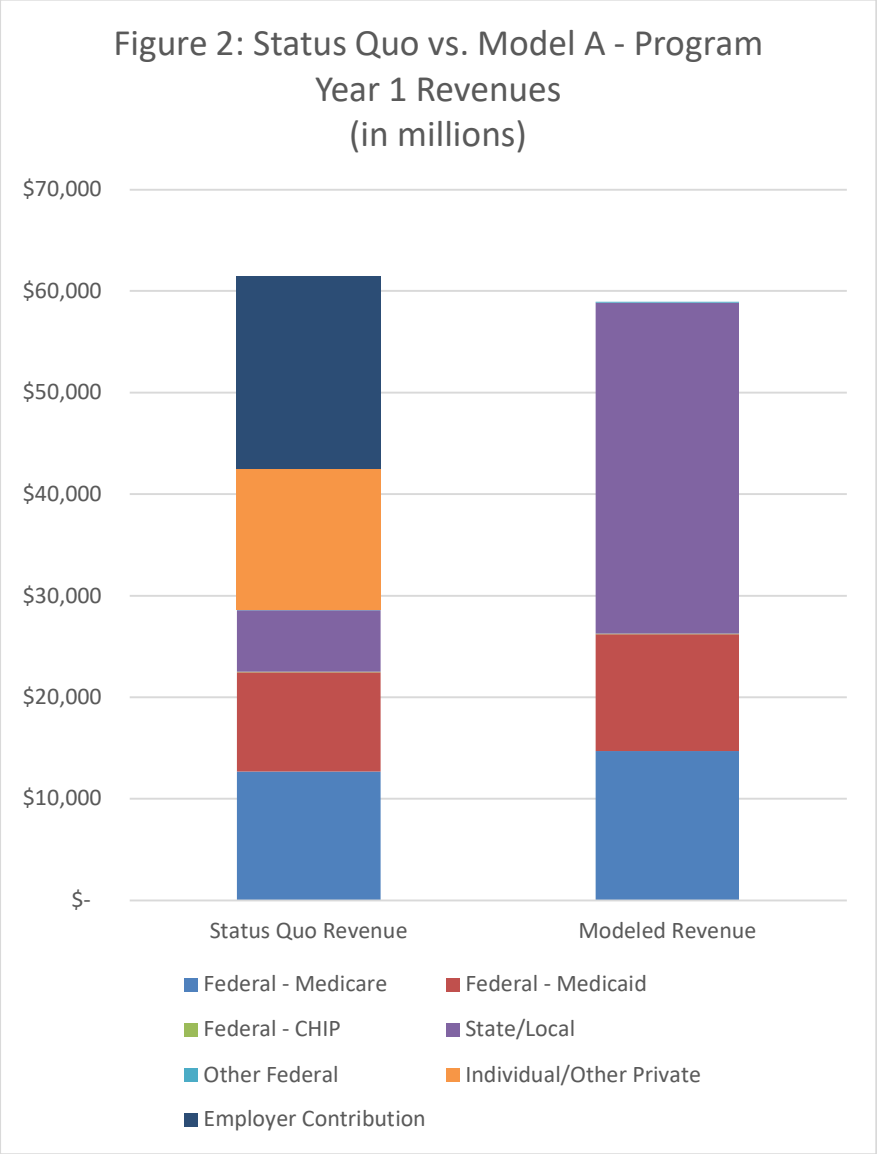
Table 2: Calendar Year 2022 Revenue Sources – Implementation Year

Financing Source	Status Quo Revenue	Model A Revenue Estimate	Differences
Federal Share – Medicaid[(1)]	$12,692,075,724	$14,719,079,266	$2,027,003,542
Federal Share – Medicare	$9,760,055,912	$11,471,950,522	$1,711,894,610
Federal Share – CHIP	$73,302,525	$87,025,380	$13,722,855
State / Local Share	$6,051,654,951	$32,586,565,837	$26,534,910,886
Other Federal Contributions (e.g. Indian Health Services)	$79,843,114	$77,511,016	$(2,332,098)
Individual Contribution	$14,057,144,852		$(14,057,144,852)
Employer Contribution [(2)]	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$58,942,132,021**	**$(2,475,570,985)**
Dental coverage for populations other than Medicaid [(3)]			**$3,052,211,853**

(1) Medicaid funding is dependent on expenditure authorities awarded to Washington by CMS and changes in federal financial participation rates. Estimates are based on pre-CARES Act federal financial participation rates.

(2) The employer contribution includes state/local funds for public employees.

(3) Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes 'moderate' cost level for dental services.



Key Notes:

- A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single payer fee schedule. There are offsetting decreases to the Private Health Insurance (employer and individual contributions). It is unclear if federal funding will be available to subsize this effect.
- Additional analysis is needed to understand the impact of lost insurer premium tax. Premium taxes contribute to the general fund. The loss of this revenue will need to be considered by the Washington Legislature.
- Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

Model A Universal Coverage – State Administered
Steady State

The following tables and figures, in CY 2022 dollars, reflect Model A at steady state, or after the program has matured. It is unclear how long it will take for the new program to achieve steady state. The primary difference between implementation year assumptions and steady state is the magnitude of savings associated with the various programatic efficiencies.

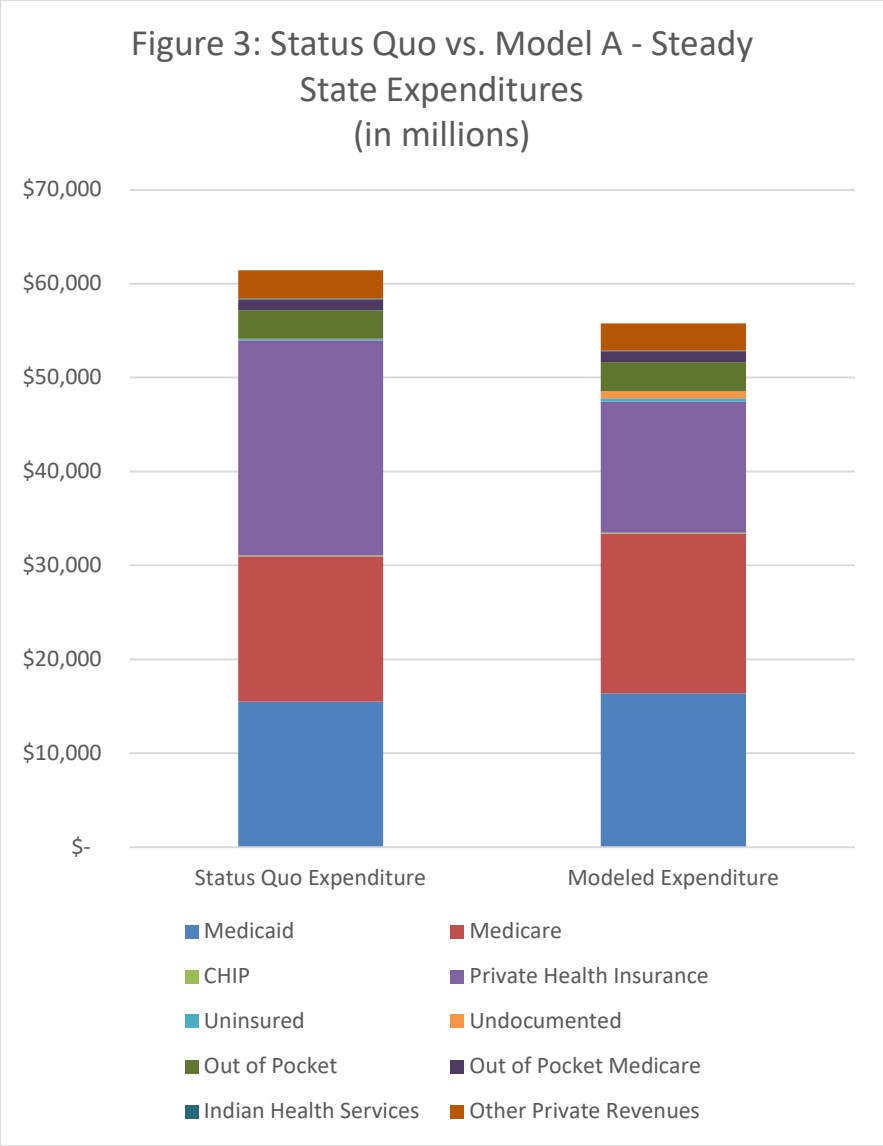
Table 3: Calendar Year 2022 Expenditures – Steady State

Financing Source	Population [1]	Status Quo Expenditures [2]	Modeled Expenditures[2]	Differences
Medicaid	1,703,992	$15,492,152,242	$16,376,945,975	$884,793,733
Medicare	1,721,504	$15,478,141,127	$16,997,807,187	$1,519,666,060
CHIP	61,707	$83,298,324	$93,163,569	$9,865,245
Private Health Insurance	3,673,661	$22,899,808,044	$13,947,804,665	$(8,952,003,379)
Uninsured	333,840	$133,818,270	$384,105,435	$250,287,165
Undocumented	124,428	$44,888,791	$740,867,936	$695,979,145
Excluded Populations	277,774			
Out of Pocket Expense (excludes Medicare)		$3,045,638,137	$3,087,211,098	$41,572,961
Out of Pocket Expense (Medicare)		$1,156,180,215	$1,171,962,075	$15,781,860
Indian Health Services		$79,843,114	$72,929,817	$(6,913,297)
Other Private Revenues		$3,003,934,742	$2,899,108,457	$(104,826,285)
Total	**7,896,906**	**$61,417,703,006**	**$55,771,906,214**	**$(5,645,796,792)**

(1) The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare covered expenditures are included in the Medicare row.

(2) Expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.

Model A Universal Coverage – State Administered Steady State



Key Notes:
Model A is expected to reduce aggregate system-wide expenditures by approximately **$5.6 billion** at steady state (in CY 2022 dollars). This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors such as the following:

- Reduced payer administrative cost
- Increased purchasing power
- Provide administrative efficiencies
- Program Integrity Improvements

The steady state model reflects higher savings assumptions as the system and data mature under the universal coverage model.

Model A Universal Coverage – State Administered
Steady State

The following table represents projected calendar year 2022 revenue estimates by financing source. These revenue projections include consideration for cost shifting dynamics that will occur due to Universal Coverage. The reader should note the following when interpreting the figures in Table 4.

- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A Universal Coverage; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the "State / Local" row for the "Model A Revenue Estimate" column.
- Model A design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payor (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in "State / Local" row for the "Model A Revenue Estimate" column.
- The revenue model assumes that the state will be successful in preserving federal funding streams for eligible populations even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 1 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

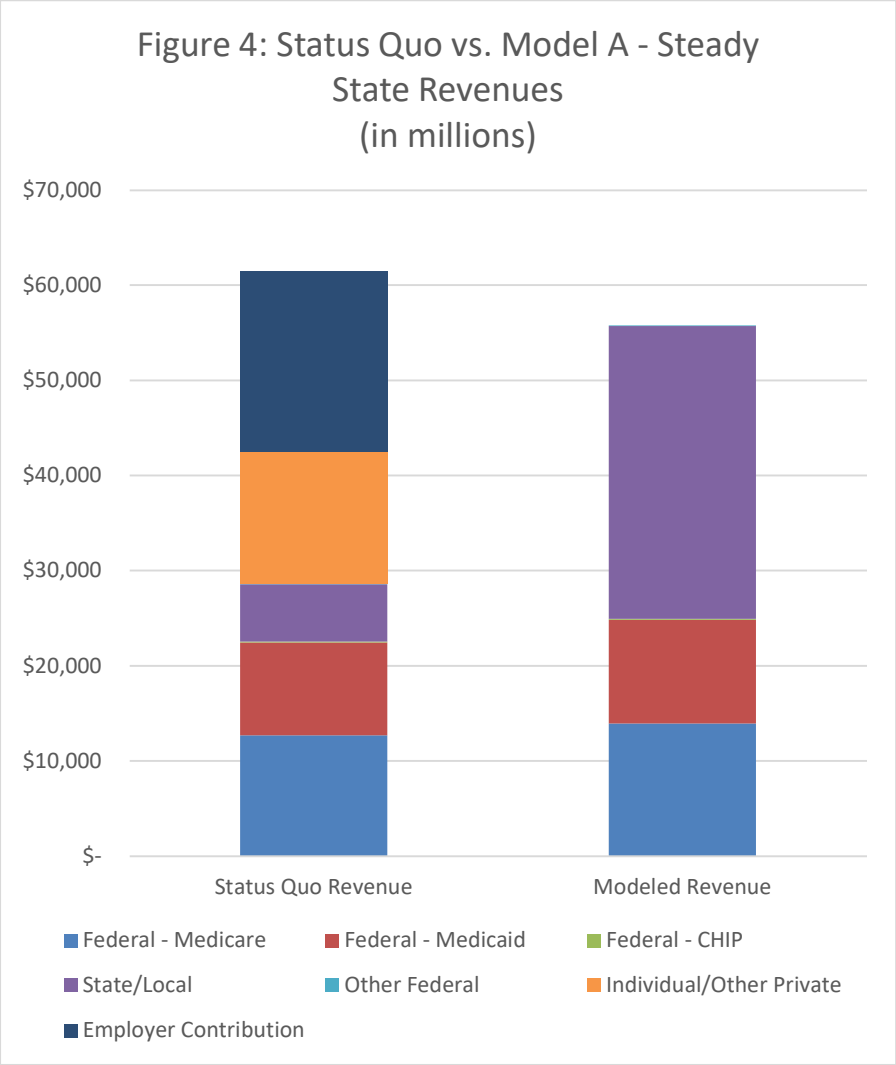
Table 4: Calendar Year 2022 Revenue Sources – Steady State

Financing Source	Status Quo Revenue	Model A Revenue Estimate	Differences
Federal Share – Medicaid	$12,692,075,724	$13,938,201,893	$1,246,126,169
Federal Share – Medicare	$9,760,055,912	$10,903,457,002	$1,143,401,089
Federal Share – CHIP	$73,302,525	$81,983,941	$8,681,416
State / Local Share	$6,051,654,951	$30,775,333,561	$24,723,678,610
Other Federal Contributions (e.g. Indian Health Services)	$79,843,114	$72,929,817	$(6,913,297)
Individual Contribution	$14,057,144,852		$(14,057,144,852)
Employer Contribution (1)	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$55,771,906,214**	**$(5,645,796,792)**
Dental coverage for populations other than Medicaid (2)			**$3,052,211,853**

(1) Employer contribution includes state/local funds for public employees.

(2) Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes 'moderate' cost level for dental services.

Model A Universal Coverage – State Administered Steady State



Key Notes:

- A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single payer fee schedule. There are offsetting decreases to the Private Health Insurance (employer and individual contributions). It is unclear if federal funding will be available to subsidize this effect.
- Additional analysis is needed to understand the impact of lost insurer premium tax. Premium taxes contribute to the general fund. The loss of this revenue will need to be considered by the Washington Legislature.
- Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

Model B Universal Coverage – Delegated Administration
Program Year 1

Overview Model B

Covered Populations	Benefits	Cost Sharing	Provider Reimbursement	Population Specific Impacts	Administration
• Medicaid • Medicare [1] • CHIP • Private Health Insurance (employer, state employees, and exchange) • Undocumented Immigrants • Uninsured	• Essential health benefits • Dental for Medicaid Eligible Only [1] • Vision • Long-term Care for Medicaid Eligible Only [1]	• No cost sharing • Private insurance utilization changes due to removal of cost sharing	• Reduced pricing variation between covered populations • Administrative efficiency • Purchasing power	• Improved access for the Medicaid Eligible population • Reflects increased utilization for uninsured and Undocumented Immigrant populations	• MCO Administered • Premium tax applies • Reflects reductions in system-wide administrative costs.

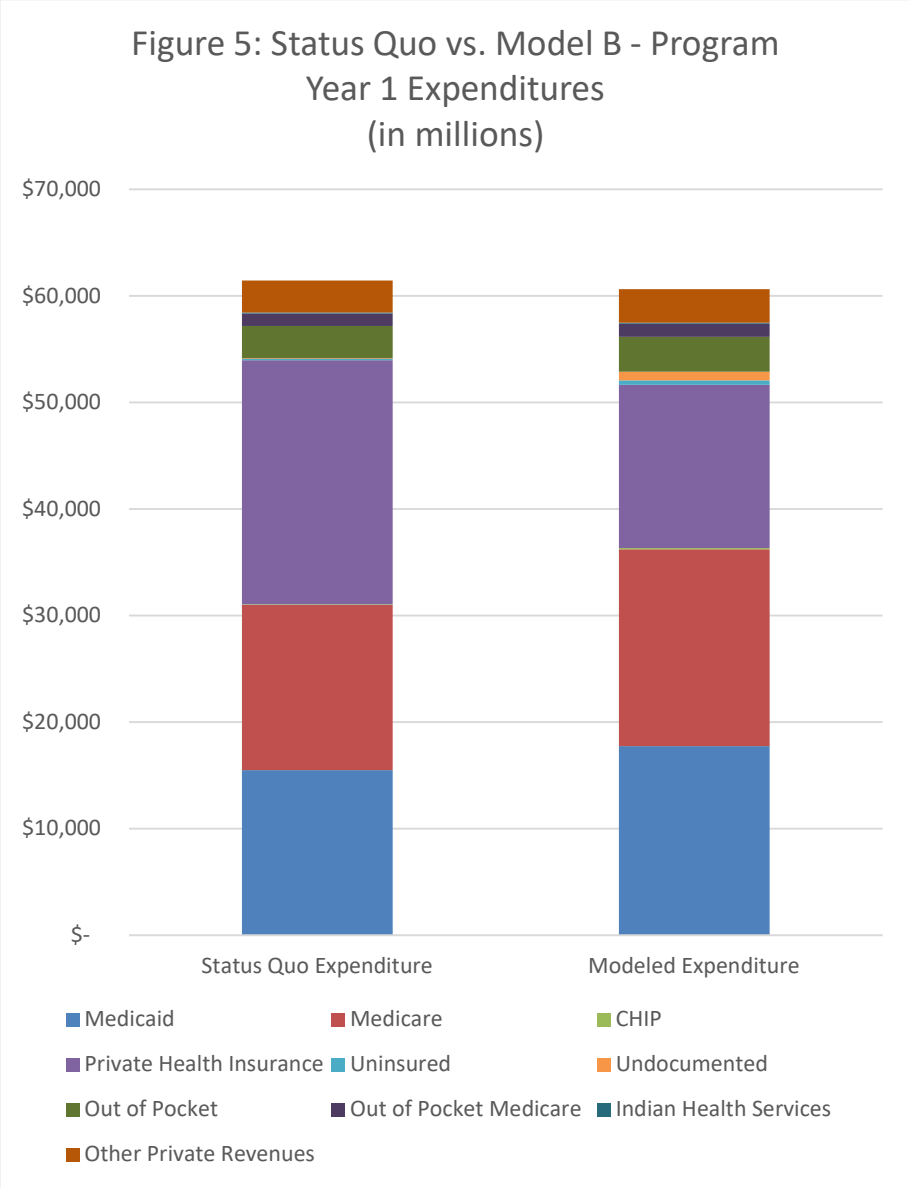
(1) As noted under presentation changes on page 1.

Table 5: Calendar Year 2022 Expenditures – Implementation Year

Financing Source	Population [2]	Status Quo Expenditures [3]	Modeled Expenditures[3]	Differences
Medicaid	1,703,992	$15,492,152,242	$17,748,246,930	$2,256,094,688
Medicare	1,721,504	$15,478,141,127	$18,465,410,446	$2,987,269,319
CHIP	61,707	$83,298,324	$101,731,496	$18,433,172
Private Health Insurance	3,673,661	$22,899,808,044	$15,316,276,699	$(7,583,531,345)
Uninsured	333,840	$133,818,270	$423,217,556	$289,399,286
Undocumented	124,428	$44,888,791	$816,307,941	$771,419,150
Excluded Populations	277,774			
Out of Pocket Expense (excludes Medicare)		$3,045,638,137	$3,265,875,845	$220,237,708
Out of Pocket Expense (Medicare)		$1,156,180,215	$1,239,786,497	$83,606,282
Indian Health Services		$79,843,114	$79,736,212	$(106,902)
Other Private Revenues		$3,003,934,742	$3,177,661,020	$173,726,278
Total	**7,896,906**	**$61,417,703,006**	**$60,634,250,642**	**$(783,452,364)**

(2) The Medicaid population totals exclude dually eligible members from the population count. Medicaid reimbursed expenditures are reflected in Medicare. All other Medicare covered expenditures are included in the Medicare row.

(3) *Expenditure totals exclude long-term care and dental for all payer sources other than Medicaid.*



Key Notes:
Model B is expected to reduce aggregate system-wide expenditures by approximately **$783 million** in the first implementation year. This impact is driven by multiple efficiencies that occur under a single-payer system. These include factors such as the following:

- Limited reduction in payer administrative cost by reducing the number of payers across the health care system.
- Increased purchasing power
- Provide administrative efficiencies
- Program Integrity Improvements

The following table represents projected calendar year 2022 revenue estimates by financing source. These revenue projections include consideration for cost shifting dynamics that will occur due to Universal Coverage. The reader should note the following when interpreting the figures in Table 6.

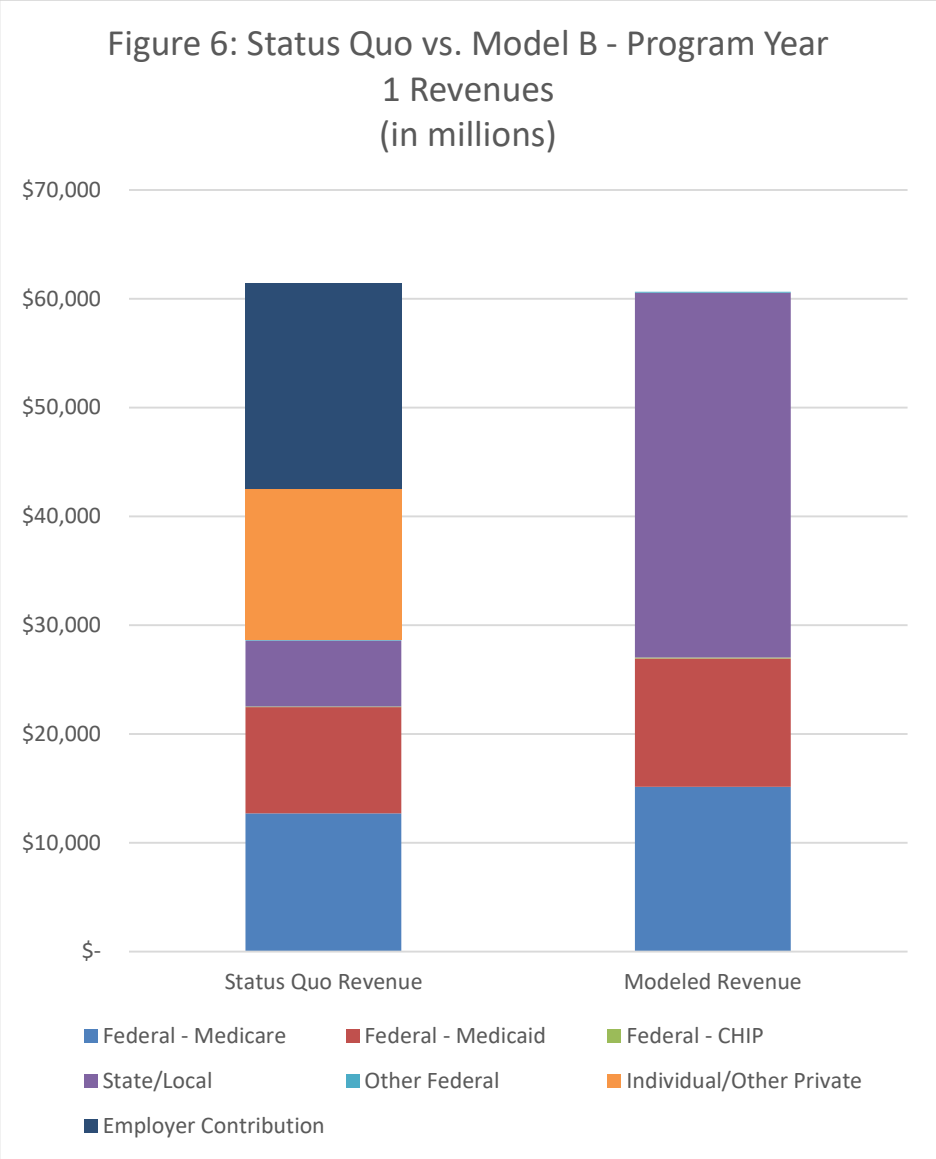
- The status quo health care system includes a significant source of funds from individual and employer contributions, including state and local funds for public employees. These revenues are assumed to continue under Model A Universal Coverage; however, a mechanism to capture these contributions will need to be developed and implemented by the Washington State Legislature. These revenues are illustrated in the State / Local row for the Model A Revenue estimate column.
- Model B design includes normalizing provider reimbursement to a single reimbursement schedule. This is a significant change from status quo where reimbursement varies by payor (Medicaid, Medicare, private coverage). Subject to federal approval, this change would increase the amount of federal contributions Washington receives but also increase state general fund obligations.
- Contributions to cover uninsured, undocumented immigrants and out-of-pocket costs are included in State / Local row for the Model A Revenue estimate column.
- The revenue model assumes that the state will be successful in preserving federal funding streams for eligible populations even with the programmatic changes associated with transition to a universal health care model.
- The revised Model A projected expenditures in Table 1 excluded the cost for dental coverage for populations other than Medicaid. The following table separately identifies revenue collections necessary for dental coverage for all populations beyond Medicaid.

Table 6: Calendar Year 2022 Revenue Sources – Implementation Year

Financing Source	Status Quo Revenue	Model B Revenue Estimate	Differences
Federal Share – Medicaid	$12,692,075,724	$15,141,636,566	$2,449,560,842
Federal Share – Medicare	$9,760,055,912	$11,801,288,814	$2,041,232,902
Federal Share – CHIP	$73,302,525	$89,523,716	$16,221,191
State / Local Share	$6,051,654,951	$33,522,065,333	$27,470,410,382
Other Federal Contributions (e.g. Indian Health Services)	$79,843,114	$79,736,212	$(106,902)
Individual Contribution	$14,057,144,852		$(14,057,144,852)
Employer Contribution (1)	$18,703,625,927		$(18,703,625,927)
Total	**$61,417,703,006**	**$60,634,250,642**	**$(783,452,364)**
Dental coverage for populations other than Medicaid (2)			**$3,052,211,853**

(1) Employer contribution includes state/local funds for public employees.

(2) Additional revenue required for covering dental services for all other populations than Medicaid, federal employees, and military. Assumes 'moderate' cost level for dental services.



Key Notes:

- A major contributor to the increase in federal funds is associated with provider reimbursement rate normalization associated with a single payer fee schedule. There are offsetting decreases to the Private Health Insurance (employer and individual contributions). It is unclear if federal funding will be available to subsize this effect.
- Additional analysis is needed to understand the broader economic impact on the state due to industry job loss, tax implications for employers, greater labor mobility, etc.

Model C Close the Gap – Coverage for Populations Currently Lacking Access to Coverage

Overview Model C

Covered Populations	Benefits	Cost Sharing	Provider Reimbursement	Population Specific Impacts	Administration
• Undocumented Immigrants	• Essential health benefits	• Standard Cost Sharing	• Cascade Care reimbursement standards apply	• Utilization assumed to be similar to the commercially insured population	• Assumes commercial plan levels of administrative costs

Model C provides coverage for populations without access to traditional health insurance coverage, independent of the affordability consideration. Currently, the population that cannot access traditional health insurance is the undocumented population. Workgroup members have expressed interest in expanding Model C to include options for those that cannot afford health insurance under the current system. Washington is already making progress in this arena through **Cascade Care**.[1] Cascade Care provides access to more affordable standard and public option plans. The authorizing statute also called for a study on a subsidy program. The Cascade Care subsidy option report is forthcoming. This report could inform recommendations for expansion of Model C to align with the subsidy recommendations, potentially serving as a transition strategy to broader universal health care in the longer term.

Population [2]	Estimated Total Cost
124,428	$617,000,000

- *Estimated current Medicaid costs (Short-Term Emergency Coverage Only): $150 million of which 50% is Title XIX federal funds.*
- *All other existing system costs for this population are assumed to be individual expense or charity care.*

[1] https://www.wahbexchange.org/about-the-exchange/cascade-care-2021-implementation/
[2] *Office of Financial Management estimate*

Dental Services

Except for the Medicaid eligible population, dental costs are not included in the models above. The table below summarizes the cost of covering the remaining populations that would be included in Model A or Model B. The estimates reflect the following:

- Standard commercial-like dental program that cover preventative, minor and major restorative services.
- Annual benefit maximums are included
- Provider reimbursement is based on commercial dental coverage
- Dental insurer administration and premium tax are excluded
- Variation in dental estimates are driven by dental managed care organization vs. preferred provider organization, annual maximum benefits limits and variation in estimates for the value of out-of-pocket costs.

Table 7: Estimated Dental Costs

	Low	Moderate	High
Average Per Member Per Month Costs	$38.00	$43.00	$48.00
Total Member Months(1)	70,981,671	70,981,671	70,981,671
Total Cost	$2.70 billion	$3.05 billion	$3.41 billion

(1) Includes member months for all populations except Medicaid, federal employee and military.

Cost Sharing

Models A and B reflect the elimination of enrollee out-of-pocket cost sharing. This results in approximately $4.2 billion in costs that were previously paid by individuals who used services and were subject to cost sharing. Eliminating out-of-pocket costs for the consumer is reflected as a plan cost that would be financed through taxes. Additionally, removing barriers to accessing care is expected to increase utilization of certain services. It is reasonable to expect some offsetting reductions in higher cost services as a result of removing cost sharing, but it may take time to see improvements in health that generates lower per capita costs. Depending on utilization controls implemented in Models A and B, removal of cost sharing could increase utilization of elective services. Additional policy development and evaluation will be required to refine cost sharing and its impact on total costs.

Multiyear Trend and Estimates

The table below summarizes the total status quo expenditures costs and Model A program costs under different start date assumptions. Weighted average growth rates are based on population specific national growth weights (from the CMS National Health Expenditures forecast) applied to the modeled estimates of expenditure and enrollment for the relevant populations.

The current 2022 estimates are based on available data from 2018 and include 4 years of projection. Projections presented in the following table become less reliable due to the everchanging dynamics in the health care system.

Table 8: 5-year Growth Rates and Estimated Change in Program Expenditures based on Different Starting Dates

Year	Growth Rate	Status Quo	Model A Implementation Year	Differences
2022		$61,417,703,008	$58,942,132,021	$(2,475,570,987)
2023	6.2%	$65,225,600,595	$62,596,544,206	$(2,629,056,389)
2024	5.9%	$69,054,863,351	$66,271,460,392	$(2,783,402,958)
2025	6.1%	$73,242,864,656	$70,290,655,409	$(2,952,209,247)
2026	6.2%	$77,804,052,454	$74,667,994,843	$(3,136,057,611)
2027	6.0%	$82,479,003,533	$79,154,512,088	$(3,324,491,445)